R590. Insurance, Administration.
R590-247. Universal Health Insurance Application Rule.
R590-247-3. General Instructions.

(1) Use of the Utah Individual Health Insurance Application and the Utah Small Employer Health Insurance Application by insurers or by health insurance producers is mandatory.

(2) The Utah Individual Health Insurance Application and Utah Small Employer Health Insurance Application must be used without insurer identifying logos or addresses to facilitate multiple insurer submissions using a single application.

(3) The Utah Individual Health Insurance Application and Utah Small Employer Health Insurance Application can be downloaded from the Department's website at www.insurance.utah.gov.

(4) The Utah Individual Health Insurance Application and Utah Small Employer Health Insurance Application may only be altered for:

(a) purposes of electronic application and submission, including electronic signature disclaimers;

(b) languages other than English; and

(c) reasons specifically approved by the commissioner.

(5) The use of the Utah Individual Health Insurance Application and the Utah Small Employer Health Insurance Application does not limit the ability of an insurer to obtain additional information for underwriting purposes.

(6) Section L, Producer Agreement and Compensation Disclosure section on the Utah Individual Health Insurance Application must include all information to be disclosed as required by Section 31A-23a-501.

(7) Question number 40 on the Utah Individual Health Insurance Application and Utah Small Employer Health Insurance Application may not be used for purposes of Sections 31A-8-402.3, 31A-8-402.5, 31A-21-105, 31A-22-721, 31A-30-107, 31A-30-107.1, or R590-247-3(5), unless the information was disclosed or should have been disclosed in another question on the application.

(8)[~~(a) Starting July 1, 2009, insurers shall accept the Utah Individual Health Insurance Application and Utah Small Employer Health Insurance Application.~~

~~(b) An insurer may accept an application other than the Utah Individual Health Insurance Application and Utah Small Employer Health Insurance Application until December 31, 2009.~~

~~(9)~~] No later than July 1, 2010, all insurers shall offer compatible systems for electronic submission of the Utah Individual Health Insurance Application and the Utah Small Employer Health Insurance Application.

(9) Effective March 22, 2010, if an employee chooses to waive coverage, an insurer shall not require such employee to complete any section of the Utah Small Employer Health Insurance Application other than sections A, B, D, E, questions 1 and 2 of section G, and J.

(10) Starting October 1, 2010, small employer insurers shall use the Utah Small Employer Health Insurance Application dated October 2010.

KEY: universal health insurance application
Date of Enactment or Last Substantive Amendment: [~~July 1, 2009~~]2010

UTAH SMALL EMPLOYER HEALTH INSURANCE APPLICATION

OFFICE USE ONLY
Policy / Group No.
Effective Date
PEC
New Hire Waiting Period

REASON FOR ENROLLMENT (mark all that apply)

❒ New Group	❒ Newborn	❒ Loss of Coverage❖
❒ Open Enrollment	❒ Court Order	❒ Marriage❖
❒ New Hire	❒ Dependent Addition	❒ Divorce❖
❒ New Application	❒ Other:_____	❒ Military Leave of Absence (USERRA) ❖
		❖ **Date of Event:** / /

❒ COBRA ❒ Utah mini-COBRA ❒ Alternative Coverage (Utah NetCare) for:
❒ Employee ❒ Dependent(s)
Length of continuation coverage: ❒ 12 mos. ❒ 18 mos. ❒ 36 mos. Other:

Original Qualifying Event Date:	Qualifying Event Date:	Date of Event:

❒ **WAIVER OF COVERAGE** **Persons waiving coverage complete only Section J.**

A. EMPLOYER INFORMATION

Employer _____ Hire Date _____ Rehire Date _____

Location _____ Is this a division? ❒ Yes ❒ No If "Yes," name of parent company _____

B. EMPLOYEE INFORMATION

Name (Last) _____ (First)_____ (MI) _____ Job Title _____ Hrs/Week _____

Marital Status ❒ Legally Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partner*

Address _____ Apt. _____ City _____ State _____ Zip _____

Home (or other) Phone (_____) _____ Business Phone (_____) _____

Spouse's Employer _____ Spouse's Business (or other) Phone (_____) _____

Email Address: _____

C. ENROLLING EMPLOYEE / SPOUSE / DOMESTIC PARTNER* / DEPENDENTS

List yourself and all other family members applying for coverage. Attach a separate sheet if necessary.

	Social Security # (for insurer use only)	Name (Last, First, MI)	Date of Birth MM/DD/YYYY	Age	M/F	Weight	Height	Coverage Requested
Employee						lbs.		❒ Medical ❒ Dental ❒ Vision
Spouse						lbs.		❒ Medical ❒ Dental ❒ Vision
Domestic Partner*						lbs.		❒ Medical ❒ Dental ❒ Vision
Dependent						lbs.		❒ Medical ❒ Dental ❒ Vision
Dependent						lbs.		❒ Medical ❒ Dental ❒ Vision
Dependent						lbs.		❒ Medical ❒ Dental ❒ Vision
Dependent						lbs.		❒ Medical ❒ Dental ❒ Vision

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26.

***Check with your employer to determine if domestic partner coverage is available.**

D. CURRENT/PRIOR COVERAGE INFORMATION

Indicate for each enrollee listed any health care coverage or Medicaid, in effect within the last 24 months. This will be used to determine if you have creditable coverage or if benefits will be coordinated. Each applicant must be listed below. If no health care coverage was in effect within the past 24 months, indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary. Attach a separate sheet if necessary.

Enrolling Individual(s): (Non-Medicare)	Insurer (Including policyholder name, insurer name and phone number)	Date of Coverage MM/DD/YYYY		Will the individual continue this coverage?	Type of Coverage (Check all that apply)
		Start Date	End Date		
Employee:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Spouse:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Domestic Partner:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical
Dependent:				❒ Yes ❒ No	❒ Group ❒ Individual ❒ Dental ❒ Medical

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. Children under age 19 are not subject to a PEC waiting period.

MEDICARE: Do you or any family members listed on this application have Medicare? ❒ Yes ❒ No If yes, is coverage ❒ Part A ❒ Part B ❒ Part D
Please complete the following information and submit a copy of your Medicare ID card with this application.

Enrolling Individual:	Effective Date:	Medicare Number / HICN (please include alpha prefix)	Reason for Medicare Entitlement: ❒ Age ❒ Disability ❒ ESRD ❒ Dual Enrollment
Enrolling Individual:	Effective Date:	Medicare Number / HICN (please include alpha prefix)	Reason for Medicare Entitlement: ❒ Age ❒ Disability ❒ ESRD ❒ Dual Enrollment

E. HEALTH STATEMENT

EACH QUESTION MUST BE CHECKED "YES" OR "NO." ALL questions must be answered and complete or the application will be returned. It is your responsibility to notify the insurer of any change in health status while this application is pending. The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. **DO NOT REPORT GENETIC INFORMATION ON THIS FORM.** Information about manifested diseases or conditions of an applicant is not considered genetic information and is to be reported, even if the disease or condition is caused by or associated with genetics. The information provided in this section may be used for rate setting, risk-adjustment or coordination of care, but will not be used to deny coverage.

	HEALTH QUESTIONS - If you answer YES to any question, please provide details in Section G.	YES	NO
1	**Pregnancy / Adoption:** Is any applicant pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months? If currently pregnant, provide expected due date_____.		
	▸ Do you anticipate complications?		
	▸ Prior/anticipated multiple births?		
2	**Transplant**: Has any applicant ever had any organ or tissue transplant?		
3	**Cancer:** Has any applicant ever had cancer (including skin cancer or melanoma)?		
4	**Medical Consult / Treatment / Recommended Care:** Excluding routine or preventative care, within the last 12 months, has any applicant been diagnosed with or treated for a health, medical or mental health condition by a health care professional?		
5	**Medication / Prescriptions:** ▸ Within the last 12 months has any applicant taken any prescribed medications?		
	▸ Within the last 12 months has any applicant taken any over-the-counter medications, such as; antacids, cold medicine, acetametaphin, ibuprofen, or topical creams, for any health condition identified in this section E?		
	▸ Within the last 12 months has any applicant been injected with a drug or medication by a health care provider or through self-administration, excluding immunizations?		
	▸ Are all applicants immunizations current?		
6	**Tobacco Use:** Has any applicant used any form of tobacco, including but not limited to cigars, cigarettes, or chewing tobacco)? If applicant has quit using tobacco give approximate quit date:_____		

HEALTH QUESTIONS CONT. - If you answer YES to any question, please provide details in Section G.		YES	NO
7	**Hospitalization / Surgery:** In the last 5 years, has any applicant been hospitalized or had surgery?		
8	**Birth Defects / Congenital Abnormalities:** In the last 5 years, has any applicant been diagnosed with or treated for premature birth (less than 37 weeks), developmental or learning disability, Down syndrome, autism spectrum disorder or congenital disorder?		
9	**Breast:** In the last 5 years, has any applicant been diagnosed with or treated for breast lumps, abnormal mammography, fibrocystic breast disorder, breast augmentation, or breast reduction?		
10	**Neurological:** In the last 5 years, has any applicant been diagnosed with or treated for recurring headaches, migraines, head injury, a seizure disorder, convulsions, or other neurological disorder? This could include but is not limited to multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia.		
11	**Mental / Behavioral:** In the last 5 years, has any applicant been diagnosed with or treated for any mental health disorder? This could include but is not limited to eating disorders, alcohol/drug abuse, stress disorder, anxiety disorder, attention deficit hyperactivity disorder (ADHD), bipolar affective disorder, manic depression, or schizophrenia.		
12	**Skin:** In the last 5 years, has any applicant been diagnosed with or treated for acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?		
13	**Back / Neck / Bone / Joint / Spine:** In the last 5 years, has applicant been diagnosed with or treated for bone or joint disorders (including foot, knee, jaw, fracture, dislocation, or joint replacement)?		
14	**Muscular / Skeletal / Connective Tissue:** In the last 5 years, has any applicant been diagnosed with or treated for neuropathy, osteoporosis, herniated and/or ruptured disc, spina bifida, scoliosis, gout, arthritis, lupus, fibromyalgia, scleroderma, a spinal condition, or other musculoskeletal disorder?		
15	**Metabolic / Endocrine:** In the last 5 years, has any applicant been diagnosed with or treated for diabetes (type I or II), thyroid disorder, goiter, or any other lymph system disorder?		
16	**Heart / Blood:** In the last 5 years, has any applicant been diagnosed with or treated for high blood pressure, high cholesterol, irregular heartbeat, heart attack, stroke, coronary artery disease, congestive heart failure or any other heart condition, or had hemophilia, anemia, any blood or circulatory disorder?		
17	**Immune System:** In the last 5 years, has any applicant been diagnosed with or treated for an immune system disease, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
18	**Respiratory / Sinus / Nose / Throat:** In the last 5 years, has any applicant been diagnosed with or treated for reactive airway disease, tuberculosis, asthma, allergies, or other respiratory conditions? This could include but is not limited to sleep apnea, pleurisy, chronic obstructive pulmonary disease (COPD), or emphysema.		
19	**Digestive:** In the last 5 years, has any applicant been diagnosed with or treated for ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, gastroesophageal reflux disease GERD, gallbladder disorder, hemorrhoids, polyps, Crohn's disease, colitis, colostomy, ileostomy, or other digestive disorder?		
20	**Urinary / Kidney / Liver:** In the last 5 years, has any applicant been diagnosed with or treated for kidney stones, jaundice, nephritis, cirrhosis, hepatitis, renal failure or other disorder of the liver, kidneys, bladder, or pancreas?		
21	**Reproductive System:** In the last 5 years, has any applicant been diagnosed with or treated for any reproductive disorder, sexually transmitted diseases, or ▸ **Male Conditions:** impotence, prostate or testicular disorder, or abnormal PSA? ▸ **Female Conditions:** irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, pelvic inflammatory disease, infertility evaluation or treatment (including medication), miscarriage, or complications related to a pregnancy?		

IF ANY OF THE QUESTIONS IN THIS SECTION WERE CHECKED "YES", PROVIDE DETAILS IN SECTIONS F & G.

F. PRESCRIPTION INFORMATION WITHIN LAST 12 MONTHS Refer to Section E

IF ANY OF THE QUESTIONS IN SECTION E WERE CHECKED "YES", PROVIDE DETAILS IN THIS SECTION. Attach a separate sheet if necessary.

Name of individual	Name of Medication	Reason for medication (Name of Illness, Disorder or Treatment)	Start Date MM /YYYY	End Date MM/YYYY	Physician, clinic, or hospital name. If known, provide phone number or address.

G. ADDITIONAL INFORMATION Refer to Section E

IF ANY OF THE QUESTIONS IN SECTION E WERE CHECKED "YES", PROVIDE DETAILS IN THIS SECTION. Attach a separate sheet if necessary.

Question #	Name of Applicant	Explain diagnosis, illness, injury, treatment received, testing, consultations, future treatments, and remaining symptoms or problems.	Diagnosis / Treatment Date(s)		Physician, clinic, or hospital name. If known, provide phone number or address.
			Start Date MM /YYYY	End Date MM/YYYY	

H. DISABILITY INFORMATION

Are you or any dependent(s) disabled? ❒ Yes ❒ No If yes, indicate first and last name(s)._____
Reason for disability:_____
Is the disabled individual currently unable to perform routine daily functions for two weeks or more? ❒ Yes ❒ No
Have you or any dependent(s) filed workers' compensation claims or disability claims within the last five years? ❒ Yes ❒ No
If so, what is the status of the claims?_____

I. ACKNOWLEDGMENT AND SIGNATURE

I agree to abide by the insurer's enrollment provisions. I understand that coverage cannot start until after I have served the waiting period agreed to by the employer as recorded on the insurer's records. I authorize my employer to act as my agent in all matters of administration of the group program, and acknowledge that my employer is in no way acting as agent for the insurer.

I acknowledge that I have had the opportunity to waive coverage for myself and any eligible family members and that I have listed those waiving coverage, if any, in Section J, "Waiver of Coverage" of this application.

I understand there may not be participating providers in all specialty fields.

I understand that credit for prior coverage will be based upon the information contained in this application and/or proof of prior coverage, such as a Certificate of Creditable Coverage that I have obtained from my prior health care insurer(s) and provided to the insurer.

If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the coverage null and void and canceling the coverage retroactive to its original effective date; or imposing the pre-existing condition waiting period and denying claims that are pre-existing, subject to credit for prior coverage.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I further certify that all information completed on this form is true, correct and complete and acknowledge my coverage may be subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect. I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms. I have also completed an authorization to disclose protected health information form, if such form accompanies this application.

Employee Signature_____ Date_____

J. WAIVER OF COVERAGE

COMPLETE WHEN WAIVING COVERAGE FOR SELF AND/OR DEPENDENTS

Employer: _____

Employee Name: (Last) _____ (First)_____ (MI) _____

PERSONS WAIVING COVERAGE

Names of persons waiving coverage	Insurer and phone number	Date of Coverage MM/DD/YYYY		Will the individual continue this coverage?	Type of Coverage (Check all that apply)
		Start Date	End Date		
Employee:				❒ Yes ❒ No	❒ Group ❒ Governmental ❒ Individual ❒ Other
Spouse:				❒ Yes ❒ No	❒ Group ❒ Governmental ❒ Individual ❒ Other
Domestic Partner:				❒ Yes ❒ No	❒ Group ❒ Governmental ❒ Individual ❒ Other
Dependent:				❒ Yes ❒ No	❒ Group ❒ Governmental ❒ Individual ❒ Other
Dependent:				❒ Yes ❒ No	❒ Group ❒ Governmental ❒ Individual ❒ Other
Dependent:				❒ Yes ❒ No	❒ Group ❒ Governmental ❒ Individual ❒ Other
Dependent:				❒ Yes ❒ No	❒ Group ❒ Governmental ❒ Individual ❒ Other

HEALTH STATEMENT

	YES	NO
Pregnancy / Adoption: Is any person waiving coverage pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months? If currently pregnant, provide expected due date: _____.		
▸ Do you anticipate complications?		
▸ Prior/anticipated multiple births?		

IF "YES", PROVIDE DETAILS IN THIS SECTION Attach a separate sheet if necessary.

Name of Individual	Explain diagnosis, illness, treatment received, testing, consultations, future treatments, and remaining symptoms or problems	Diagnosis/Treatment date(s)		Physician, clinic, or hospital name. If known, provide phone number or address.
		Start Date MM /YYYY	Start Date MM /YYYY	

ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed above. In waiving coverage, I am aware that waiving members (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving member qualifies for a Special Enrollment Period (SEP). If I have waived enrollment for myself or any of my dependents (including my spouse) because of other health care coverage or group health plan coverage, I may in the future be qualified for a SEP and be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage (within 60 days if the other coverage was Medicaid or CHIP). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I further certify that all information completed on this form is true, correct and complete, and acknowledge my coverage is subject to cancellation or other action permissible by law, if any completed information is found to be false or incorrect.

Employee Signature_____Date_____

NOTICE OF
PROPOSED RULE AMENDMENT

- The agency identified below in box 1 provides notice of proposed rule change pursuant to Utah Code Section 63G-3-301 and Subsection 53C-1-201(3)(c).
- Please address questions regarding information on this notice to the agency.
- The full text of all rule filings is published in the Utah State Bulletin unless excluded because of space constraints.
- The full text of all rule filings may also be inspected at the Division of Administrative Rules.

Agency Information

1. Agency: Insurance - Administration
   Room no.: 3110
   Building: STATE OFFICE BLDG
   Street address 1: 450 N MAIN ST
   Street address 2:
   City, state, zip: SALT LAKE CITY UT 84114-1201
   Mailing address 1: PO BOX 146901
   Mailing address 2:
   City, state, zip: SALT LAKE CITY UT 84114-6901

   Contact person(s):

Name:	Phone:	Fax:	E-mail:
Jilene Whitby	801-538-3803	801-538-3829	jwhitby@utah.gov

(Interested persons may inspect this filing at the above address or at DAR during business hours)

Rule Information

DAR file no: 33644 Date filed: 05/13/2010 03:09 PM
State Admin Rule Filing Key: 149750
Utah Admin. Code ref. (R no.): R 590 - 247 - 3
Changed to Admin. Code ref. (R no.): - -

Title

2. Title of rule or section (catchline):
   General Instructions.

Notice Type

3. Type of notice: Amendment

Rule Purpose

4. Purpose of the rule or reason for the change:
   House Bill 294, Health System Reform Amendments, was passed by the Utah Legislature and put into effect March 22, 2010. The bill includes a change to 31A-22-635, Development of Uniform Health Insurance Application--Uniform Waiver of Coverage. The changes deal with what can be required for employees waiving coverage. New wording requires the use of a uniform waiver of coverage form that limits what can be asked. The department has developed this waiver form with the health insurance industry. The rule will provide needed guidelines to the health care industry in Utah. The new wording also requires the department to shorten the application.

Response Information

5. This change is a response to comments by the Administrative Rules Review Committee.
   No

Rule Summary

6. Summary of the rule or change:
Changes to the rule require health insurers to shorten the uniform health insurance application and create a uniform waiver as now required in 31A-22-635(2)(a)(ii).

Aggregate Cost Information

7. Aggregate anticipated cost or savings to:
A) State budget:
Affected: No
The change to this rule will create no additional work or revenue, nor will there be a cost savings for the department. The rule simply revises the application and creates a waiver form when an employee waiver coverage.
B) Local government:
Affected: No
This rule deals solely with the relationship between the department and its health insurance licensees. It will have no impact on local governments.
C) Small businesses:
Affected: No
("small business" means a business employing fewer than 50 persons)
This change affects health insurance policies sold to small employers with less than 50 employees. It will affect the questions an employee will have to answer in relation to an insurance waiver they fill out. The change in the questions to be asked will have no fiscal impact on the employer or the employee except that there will be fewer questions to answer. The waiver applies to employees that waive health insurance coverage. The changes also simplify the application for persons applying for coverage.
D) Persons other than small businesses, businesses, or local government entities:
Affected: No
("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an agency)
This rule does not apply to large employers. It applies to employees waiving health coverage so there is no cost to them. Depending on how the insurer makes the changes to their waiver form there may be some minor cost.

Compliance Cost Information

8. Compliance costs for affected persons:
Small employers will not be impacted financially. The insured will have fewer questions to answer. The insurer will have costs associated with the changes that will need to be made to their applications to comply with the new law.

Department Head Comments

9. A) Comments by the department head on the fiscal impact the rule may have on businesses:
The changes to this rule will have no fiscal impact on small employers. It may have a minor fiscal impact on health insurers doing business in Utah.
B) Name and title of department head commenting on the fiscal impacts:
Neal T. Gooch, Acting Insurance Commissioner

Citation Information

10. This rule change is authorized or mandated by state law, and implements or interprets the following state and federal laws.
State code or constitution citations (required) (e.g., Section 63G-3-402; Subsection 63G-3-601(3); Article IV) :
31A-30-102

31A-22-635

31A-22-635

Incorporated Materials

11. This rule adds, updates, or removes the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to DAR; if none, leave blank) :

Official Title of Materials Incorporated (from title page):
Publisher:
Date Issued:
Issue, or version:
ISBN Number:
ISSN Number:
Cost of Incorporated Reference:
Adds, updates, removes:

Comments

12. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. The agency is required to hold a hearing if it receives requests from ten interested persons or from an association having not fewer than ten members. Additionally, the request must be received by the agency not more than 15 days after the publication of this rule in the Utah State Bulletin. See Section 63G-3-302 and Rule R15-1 for more information.)

A) Comments will be accepted until 5:00 p.m. on (mm/dd/yyyy) : 07/01/2010

B) A public hearing (optional) will be held:

On (mm/dd/yyyy):	At (hh:mm AM/PM):	At (place):
06/21/2010	01:00 PM	The Copper Room in the East building, behind the Capitol, 420 N State St, Salt Lake City, UT 84116

Proposed Effective Date

13. This rule change may become effective on (mm/dd/yyyy): 07/08/2010

NOTE: The date above is the date on which this rule MAY become effective. It is NOT the effective date. After the date designated in Box 12(A) above, the agency must submit a Notice of Effective Date to the Division of Administrative Rules to make this rule effective. Failure to submit a Notice of Effective Date will result in this rule lapsing and will require the agency to start the rulemaking process over.

Indexing Information

14. Indexing information - keywords (maximum of four, in lower case, except for acronyms (e.g., "GRAMA") or proper nouns (e.g., "Medicaid")):

universal
insurance
health
application

File Information

15. Attach an RTF document containing the text of this rule change (filename):

There is a document associated with this rule filing.

To the Agency

Information requested on this form is required by Sections 63G-3-301, 302, 303, and 402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the Utah State Bulletin, and delaying the first possible effective date.